Keeping confidential information confidential

Many will be grateful for your articles on child abuse, and the letter by Margaret Crawford and colleagues (Jan 3, p 25)[1] documenting the variable way UK clinicians have responded to Lord Laming's recommendation about keeping all of a child's records together.

However, what is really at issue here is not how common this policy is, but how right it is. Has anyone asked those responsible for the Child and Adolescent Mental Health Service what they think? Whose file do you put such papers in when it is a family you are trying to help? Are clinicians not in contempt of family court obligations if papers seen by the court are not treated with more care than this?

I have encountered three cases of non-consensual incest in which a man had fathered his own daughter's child. When these came to light, the evidence was passed to social services, who confronted the family and had the issue resolved without ever involving the courts (believing that this would have just increased family stress). The notes contained no overt mention of what happened—they merely said very clearly that certain concerns had been shared with the family after the babies' delivery and passed to social services. I did speak to the family doctor, and sent the practice a written note, but no second copy was ever kept.

I am prepared to listen carefully to what Lord Laming says. However, my conscience would not have let me put some things down on paper if I thought I would be required to place a copy in a file that would probably be trawled through by several hundred doctors, nurses, clerks, secretaries, and administrators over the next 10 or even 20 years. Resolution only occurred because I felt able to promise that the facts would only become known to those who needed to know.

I declare that I have no conflict of interest.

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1 Crawford M, Fleming P, Moghal N. The fragmented clinical record: a risk to at-risk children. *Lancet* 2009; **373:** 25.

Responding to child maltreatment: French physicians under fire

I would like to add another view relating to the paper on recognising and responding to child maltreatment by Ruth Gilbert and colleagues (Jan 10, p 167).[1]

On Dec 5, 1998, I was sanctioned by the French medical board and charged with three counts of false reporting, each carrying a 3-year ban from practice. My case was aired in the media a few weeks later. Thereafter, more and more colleagues became the subject of disciplinary action and law suits. This has created a climate of fear and doubt among physicians, thus deterring reports of maltreatment.[2]

In 2002, Juan Miguel Petit, the UN Special Rapporteur, came to France. He recommended that "the French National Medical Board urgently review its procedures in order to support rather than condemn doctors who report their suspicions of child abuse."[3] The French parliament forbade disciplinary sanctions in the penal code on Jan 2, 2004.

In 2005, Hina Jilani, the UN Special Representative welcomed the change but commented that she "remains, however, preoccupied that this legislation and the way it is implemented may not go far enough in effectively shielding physicians against abusive complaints".[4]

On Nov 6, 2008, two general practitioners received a suspended prison sentence of 3 years in the Douai Court after a 5-year-old child died from abuse. These colleagues said they did not recognise that the child had been abused.

Might the Douai tragedy have been prevented if a stronger law had been enacted, which obliges doctors to report suspected abuse and which confers immunity from disciplinary and legal proceedings reports made in good faith and accompanied by proper training?

I am a Member of Professionals Against Child Abuse.

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1 Gilbert R, Kemp A, Thoburn J, et al. Recognising and responding to child maltreatment. *Lancet* 2009; **373:** 167–80.
2 Bonnet C. L'enfance muselée. Bruxelles: Thomas Mols, 2007.
3 Petit JM. Report on the mission to France 25–29 November 2002. http://www.unhchr.ch/html/menu2/2/60chr/summaries/13_E.doc (accessed Feb 4, 2009).
4 Jilani H. Promotion and protection of human rights/human rights defenders: summary of cases transmitted to Governments and replies. March 16, 2005. Report E/CN.4/2005/101/Add.1: 89–92. http://ap.ohchr.org/documents/dpage_e.aspx?m=70 (accessed Feb 10, 2009).

Bibliometrics, research quality, and neglected tropical diseases

Increasingly academics and research institutions are being judged on the quality of their research by how frequently their published work is cited by others. Citation rates and H factors are now making or breaking researchers' careers and influencing how much money institutions and universities receive.

Although this move towards a more objective assessment of research quality should be applauded, the potential for systematic biases could still exist. Mostly these citation rates are dependent on a

single commercial database and search engine (Web of Knowledge), although there is at least one other rival provider (Scopus).

I have studied the effect of choice of database on citation rates per publication for several tropical[1] and non-tropical infectious diseases. I calculated citation rates per disease from citations in 2007 to papers published in the years 2004–06 for the two databases above. I then included citation rate ratios in a meta-analysis done with StatsDirect.

Rather more papers were listed in Scopus than Web of Knowledge, reflecting the larger number of medical journals included in the former. However, Scopus listed 55% more papers on the chosen tropical infections than Web of Knowledge, compared with only 35% more for the non-tropical diseases. The citation rate ratios are shown in the figure. For the non-tropical diseases, citation rates were roughly equal between the two databases, whereas citation rates for the tropical disease were significantly higher in Scopus.

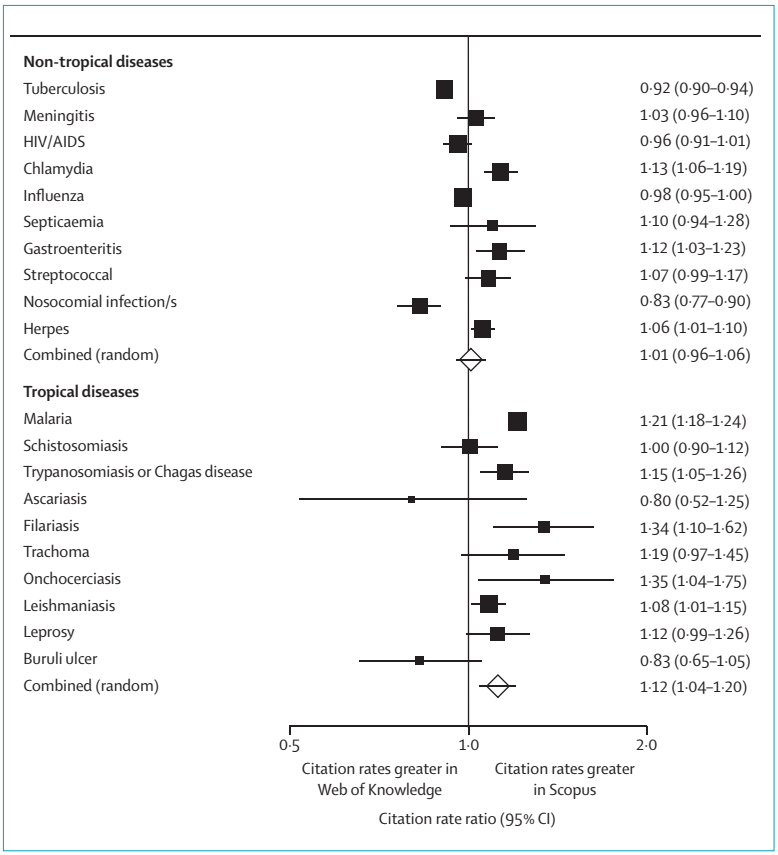

Figure: **Citation rate ratios for selected tropical and non-tropical diseases**

The reasons for this discrepancy are reasonably obvious. Scopus references many more journals than Web of Knowledge, at least in the medical arena, and journals from developing countries are much more likely to feature in Scopus. This not only makes it less likely that tropical researchers will have their work listed by the market leader, but even if it is, many of the citations to their work will not be detected. It was not possible to compare citation rates for papers published in both databases, although, had this been possible, it is likely that the discrepancy in citation rates would have been even greater because many of the additional papers cited in Scopus are likely to have had lower citations.

It could be argued that what matters is that tropical disease researchers are compared with others in the specialty. However, this view would be naive. Many researchers on tropical disease issues also work on diseases of the developed world and compete for jobs and promotion in departments where developed-world researchers also work. It is essential that when using citation rates to make decisions about funding, employment, or promotion of researchers, due account is made of the possible effect of inclusion criteria of the databases used. Otherwise the neglected tropical diseases will become even more neglected.

Scopus is a product of Elsevier—the publisher of *The Lancet*. I declare that I have no conflict of interest.

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1 Hotez PJ, Molyneux DH, Fenwick A, et al. Current concepts—control of neglected tropical diseases. *N Engl J Med* 2007; **357:** 1018–27.

Occult gunshot wounds in the emergency department

The treatment of gunshot wounds is becoming more frequent in some emergency departments within the UK. Diagnosis is usually easily made from the presented history, making it the least challenging part of patients' management. However, owing to fear of police involvement,[1] the history could be deliberately misleading. We present two cases with no initial suspicion of gunshot wounds, but in whom the diagnosis was made incidentally after radiographic studies.

The first patient was an adult who presented to the emergency department of a central London hospital with a vague history of blunt facial trauma during an altercation. Initial examination revealed a small